

VIEWS AND POLICIES CONCERNING POPULATION GROWTH AND FERTILITY AMONG GOVERNMENTS IN INTERMEDIATE FERTILITY COUNTRIES

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INTRODUCTION

This paper discusses Government views and policies concerning population growth and fertility level, as well as their determinants, in intermediate fertility countries; i.e., countries with a total fertility rate under 5 children per woman but above replacement level. The information for this paper is derived from a variety of sources: official replies of Governments to the United Nations Population Inquiries, national reports, official statements at population conferences, and material provided by Government agencies as well as the world press. The data analyzed cover the period of a quarter of a century, from 1976 to 2001, roughly paralleling the period from adoption by Governments of the World Population Plan of Action in Bucharest in 1974, to the adoption at the special session of the General Assembly in 1999 of key actions for further implementation of the Programme of Action of the International Conference on Population and Development.

Some general trends in Government views and policies are discussed for the whole world and the less developed regions. However, the focus of the paper is on the 67 intermediate fertility countries where 43 per cent of the world population currently lives. This group includes the most populous countries and the largest birth contributors: Bangladesh, Brazil, Egypt, India, Indonesia, Islamic Republic of Iran, Mexico, Philippines, South Africa, Turkey and Viet Nam, as well as some rather small countries in the Caribbean and Oceania. Several of the intermediate fertility countries have experienced a rapid decline in fertility (for example, Algeria, Bahrain, Brazil, Indonesia, Iran, Kuwait, Lebanon, Mexico, Mongolia, Suriname, Tunisia, Uzbekistan and Viet Nam), while others have had a more gradual decrease (for example, Argentina, Bolivia, Botswana, Fiji, Ghana, Guatemala, Haiti, Israel, Lesotho, Nepal, Papua New Guinea, Paraguay, Samoa, Sudan, Swaziland, Uruguay and Vanuatu). In many of these countries, there was strong political commitment to population policy development and family planning for decades. In others, the Government did not play such a major role and did not have an explicit population policy. This paper considers some common features and peculiarities of national policies related to fertility.

A. GOVERNMENT VIEWS

1. *Population growth*

As a result of progress in medicine coupled with public health measures and the consequent dramatic reduction in death rates after the Second World War, population growth rates, particularly in the less developed regions, reached unprecedented levels in the second half of the twentieth century. Among the first countries that expressed concern that rapid rates of population growth were undercutting their prospects for achieving socio-economic objectives were India, Pakistan and the Republic of Korea in Asia, and Egypt in Africa. Some of these countries already had high population density: the Republic

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of Korea with 206 persons per square kilometre and India with 109 in 1950. Although Egypt's land was vast, and population density was only 22 persons per square kilometre, almost all of the population (over 90 per cent) was squeezed into the Nile Valley and its fertile delta, and along the Mediterranean coast.

In 1976, two years after adoption of the World Population Plan of Action, over one third of Governments in the world and 41 per cent in the less developed regions perceived their growth rate to be too high. This proportion was particularly high among the countries of Latin America and the Caribbean (48 per cent). By 2001, continued high rates of population growth have remained an issue of policy concern for many countries of the developing world. The proportion of Governments in the less developed regions perceiving their growth rate to be too high steadily increased to 54 per cent in 2001.

Among the intermediate fertility countries, 53 per cent of Governments in 1976 perceived their population growth rate to be too high. This percentage fell to 46 per cent in 1986, before rising back again to 51 per cent in 2001 (see tables 1 and 2). Among the 42 countries with a total fertility rate between 2.1 and 3.5 children per woman, 38 per cent in 2001 considered their rate of population growth to be too high. In contrast, in the 25 countries with a total fertility rate between 3.5 and 5, this proportion was 72 per cent (see table 2).

While in Asia and Oceania the proportion of Governments perceiving their population growth to be too high decreased between 1976 and 2001, in Latin America and the Caribbean it remained practically at the same level. In contrast, in African countries, it steadily rose from 1976 to 1996 and then remained at the same level. Only two countries in Africa consider their population growth rates satisfactory: Libyan Arab Jamahiriya and Tunisia. Currently, countries with intermediate fertility that view population growth as too high encompass almost all those in Africa (85 per cent), 46 per cent in Asia and Oceania, and 40 per cent in Latin America and the Caribbean.

The majority of countries in Asia and Oceania considered their population growth rates to be too high throughout the quarter century from 1976-2001. In the 1990s, Jordan and Tajikistan also shifted to this view. In contrast, first Fiji, Kuwait and Mongolia shifted to a view of their population growth as being satisfactory, then later Malaysia, Qatar and Uzbekistan. Of the nine intermediate fertility countries of Western Asia, five consider their population growth rate to be satisfactory and Israel considers it to be unsatisfactory because it is too low. The main goal of population policy in Israel is to increase the size of the population. Higher population growth rates are encouraged through measures aimed at increasing fertility as well as immigration. Kuwait considered its population growth rate to be satisfactory in the early 1990s, but expressed a mixed view of its growth rate in the late 1990s. The Government viewed the growth rate of Kuwaiti nationals as satisfactory and that of non-nationals as too high.

2. Fertility level

In the intermediate fertility countries, the proportion of Governments that viewed their fertility as too high decreased from 61 per cent in 1976 to 44 per cent in 1986, then after rising back to 60 per cent in 1996, leveled off at 57 per cent in 2001 (see tables 3 and 4). In the group of 42 countries with TFR between 2.1 and 3.5 children per woman, 45 per cent considered fertility as too high in 2001. In contrast, among the 25 countries with TFR between 3.5 and 5 children per woman, 76 per cent said that fertility was too high (see table 4).

Since 1976, the proportion of Governments that viewed their fertility as too high has declined among the intermediate fertility countries of Asia and Oceania and of Latin America and the Caribbean. Some countries have shifted their view of fertility from too high to satisfactory—two countries in Asia and Oceania (Bahrain and Fiji) did so, as did four countries in Latin America and the Caribbean (Chile, Colombia, Costa Rica and Panama). In contrast, the proportion that viewed fertility as too high has increased in Africa since 1976. Three African countries have shifted their view of fertility level from satisfactory to too high—Algeria, Cape Verde and Sudan. In 2001, the proportion of Governments that viewed their fertility as too high was 46 per cent in Asia and Oceania and 52 per cent in Latin America and the Caribbean and 92 per cent in Africa. Currently, the Libyan Arab Jamahiriya is the only intermediate-fertility African country that considers its fertility level to be satisfactory.

The proportion of the intermediate fertility countries currently viewing their fertility as satisfactory is high in Western Asia (56 per cent), where only two countries, Jordan and Turkey, consider their fertility to be too high. In contrast, Israel has steadily considered its fertility as too low. The United Arab Emirates has also recently shifted to such a view. The Government of the United Arab Emirates has expressed concern with the demographic imbalance in the country, particularly related to the low fertility rate of national women. In his address to a 2001 Women's Association Conference on enhancing childbearing among UAE national families and encouraging them to have more children, Sheikh Humaid characterized the existing demographic imbalance as society's most prominent challenge, which bears economic, cultural, social, and security consequences. He called on all institutions of society to work out effective plans to curb this imbalance.

Two thirds of the intermediate fertility countries in South America consider the level of fertility as satisfactory, and Uruguay even considers it as too low. Only Ecuador, Paraguay and Peru consider it as too high.

3. Family planning and reproductive health

The views of Governments with respect to family planning over the last three decades have transformed considerably. Since the adoption of the World Population Plan of Action at the 1974 Bucharest Conference, an increasing number of Governments have accepted the idea that Government actions could slow population growth. At the following international conferences in 1984 and 1994, most Governments have reaffirmed the need for effective family planning programmes to slow population growth and promote health.

The Governments of India and many other countries have increasingly considered it important to integrate family planning with maternal and child health programmes. The public health approach to family planning programmes has been reinforced in the international arena in the 1990s. The Governments of the Islamic Republic of Iran and some other countries expressed that the family planning programme should allow couples to decide for themselves how many children they desired, rather than serve as a vehicle for population reduction. These Governments further suggested that the programmes should offer services and remedies not only to couples who wish to limit their family size but also to those who experience difficulty conceiving.

The ICPD Programme of Action defined reproductive health for the first time in an international document, stating that: reproductive health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system... ” It also said that reproductive health care should enhance individual rights, including the right to decide freely and responsibly “the number and spacing of one's children”.

Reproductive health encompasses many elements, including contraceptive information and services, prenatal care, safe childbirth and postnatal care, prevention and treatment of STIs, including HIV/AIDS, prevention and treatment of infertility; elimination of harmful practices, and violence against women. The Programme of Action calls for all countries to provide these services, mainly through the primary health care system, by 2015. Governments have adopted a life-cycle approach to reproductive health that is based on the understanding that the situation of women during pregnancy and childbirth depends on their experience in childhood and adolescence.

4. Child mortality

Addressing population growth concerns in the World Population Plan of Action and the ICPD Programme of Action, Governments had recognized the interrelationship between fertility and mortality levels. Reducing infant, child, and maternal mortality is seen to lessen the need for high fertility and reduce the occurrence of high-risk births. In 2001, some 83 per cent of countries in less developed regions considered the level of under-five mortality to be unacceptable. In intermediate fertility countries, this proportion was 79 per cent. Every country in Africa considered its under-five mortality to be too high, as did 84 per cent in Latin America and the Caribbean and 64 per cent in Asia and Oceania (see table 5). The region of Western Asia is notable in that two thirds of Governments consider child mortality acceptable.

5. Maternal mortality

Maternal mortality is another serious concern for Governments. In 2001, only one fifth of Governments in the intermediate fertility countries found their level of maternal mortality to be acceptable (see table 6). These included eight countries in Asia and Oceania (Brunei Darussalam, Fiji, Israel, Kuwait, Lebanon, Qatar, Syrian Arab Republic and United Arab Emirates) and five countries in Latin America and the Caribbean (Argentina, Bahamas, Chile, Costa Rica and Jamaica).

The maternal mortality ratio in the intermediate fertility countries varies from 8 maternal deaths per 100,000 live births in Israel to 1,300 maternal deaths in Kenya and 1,500 in Sudan. About 60 per cent of births in less developed countries occur outside health facilities. Births attended by trained health personnel in Bangladesh, for example, accounted for only 8 per cent in 1990-1997 (UNICEF, 1999). This affects health and mortality of both mothers and children. And even deliveries in health facilities can still be risky because of poor medical care. The Programme of Action called on Governments to aim for maternal mortality ratios below 60 deaths per 100,000 live births in all countries. At the General Assembly's review of the implementation of ICPD Programme of Action, a new benchmark called for high mortality countries is to ensure that at least 60 per cent of births are assisted by trained health personnel.

6. Abortion

According to WHO estimates, 13 per cent of maternal deaths result from complications from abortion. These complications particularly arise from unsafe procedures, which usually occur where abortions are illegal or inaccessible. Abortion is one of the most divisive health issues that Governments face. The international consensus hammered out at the Cairo Conference is that unsafe abortion should be addressed to reduce its adverse health impacts. In the Programme of Action, Governments declared that "in no case should abortion be promoted as a method of family planning" (United Nations, 1995).

Replies to the Seventh and Eighth United Nations Inquiries among Governments on Population and Development show that abortion is a matter of growing concern for Governments. Of 50 Governments in the intermediate fertility countries that responded to the question on abortion, 32 (64 per cent) considered it a matter of concern (see table 7). Seven countries expressed no concern on the issue (Morocco, Tunisia, and Sudan in Africa; Israel, Islamic Republic of Iran, Jordan, Tajikistan and Turkey in Asia). Four countries (Bangladesh, Ghana, India, and Indonesia) did not have an official position in the Seventh Inquiry, but in the Eighth Inquiry reported their concern.

7. Adolescent fertility

Adolescent fertility is a growing concern for Governments, particularly in less developed regions. It is related to the fact that young people constitute a high proportion of the population in the less developed countries. The recent increase in sexual activity among adolescents in some countries is frequently accompanied by an increase in teen-age pregnancies, and the spread of AIDS. Young people are more vulnerable than adults to unplanned pregnancies and to HIV and other STIs. Since adolescence is the period of formation, transition from childhood to adulthood, the experience of people in adolescence impacts their entire lives. Their decisions about marriage, sexual activity, and childbearing have major implications for societies.

In 2001, of the 53 intermediate fertility countries for which information was available 30 (57 per cent) viewed adolescent fertility as a major concern (see table 8). The level of concern varied among regions. It was 40 per cent among the countries of Asia and Oceania, 55 per cent in Africa, and 73 per cent in Latin America and the Caribbean. Some countries that expressed no concern in the Seventh Inquiry, changed their view in the Eighth Inquiry to expressing high concern (Colombia, Myanmar and Turkey) or a minor concern (Algeria and Tunisia). Other countries shifted from minor to major concern (Bahamas, Bangladesh and Malaysia). However, a number of countries like Nepal in Asia, and Bolivia and Guatemala in Latin America, which exhibit high teenage fertility rate (between 116 and 136 children per 1,000 women aged 15-19) express only minor concern regarding adolescent fertility. Only 8 countries express no concern with this issue (Sudan and Swaziland in Africa; and Bahrain, Brunei Darussalam, Jordan, Kuwait, Kyrgyzstan and Tajikistan in Asia).

B. POLICY INTERVENTIONS

1. *Policy objectives with respect to population growth*

In 2001, some 33 of 67 intermediate fertility countries (49 per cent) had policies aimed at lowering population growth, while 8 (12 per cent) had policies aimed at maintaining it and only 2 countries, Israel and Uruguay, had policies to raise it. Some 24 Governments (36 per cent) had a policy of non-intervention (see tables 1 and 9). While in countries with total fertility between 2.1 and 3.5, the proportion of those with a policy to lower population growth was 38 per cent, in countries with TFR between 3.5 and 5 children per woman, it was much higher – 68 per cent (see table 9).

Throughout the quarter century since 1976, many intermediate fertility countries steadily maintained their commitment to reduce population growth: two thirds of countries in Africa (Botswana, Egypt, Ghana, Lesotho, Morocco, South Africa and Tunisia), one fourth of those in Asia and Oceania (Bangladesh, India, Indonesia, Nepal, Papua New Guinea, Philippines, Samoa, Turkey and Viet Nam); and almost one fourth in Latin America and the Caribbean (Dominican Republic, El Salvador, Haiti, Jamaica, Mexico and Santa Lucia). Some countries shifted to a policy of reducing population growth during these decades. In the 1990s, such a change in policies was made by the Islamic Republic of Iran and Jordan in Asia and Oceania; Cape Verde, Sudan and Swaziland in Africa; and Guatemala and Nicaragua in Latin America and the Caribbean.

In contrast, Malaysia has changed its policy from one of lowering the population growth rate and no longer intervenes to reduce it. This corresponds to the steady decline of its population growth rate that has resulted mainly from the decline in overall fertility. Costa Rica and Honduras have also shifted from a policy of lowering the population growth rate to one of non-intervention. The Government of Kuwait has adopted a policy to maintain the present rate of growth for Kuwaitis and to reduce the rate of growth for non-Kuwaitis.

Since the concern with population growth issues arose, several Governments identified quantitative targets in their development plans to reduce the population growth rate, for example Ghana, India, Indonesia, the Islamic Republic of Iran, the Philippines and Turkey. India has needed to delay its targets for the growth rate and fertility level. For example, the targets of achieving the net reproduction rate of 1 and the birth rate of 21 have moved from the year 2000 to the period 2011-2016. In contrast, Indonesia achieved its targets ahead of schedule. In general, however, particularly since the 1990s, national programmes are shifting their emphasis from quantitative to qualitative issues, with the focus being on satisfying unmet needs and on a “people- and family-centred” approach”.

2. *Policy objectives with respect to fertility*

In 2001, all the countries that have taken action to reduce their rate of population growth pursued that objective through programmes aimed at lowering their fertility level. In addition, six countries in 2001 indicated a policy of non-intervention in regard to their population growth rate while continuing a policy to lower fertility (Bahamas, Bahrain, Costa Rica, Honduras and Malaysia).

The proportion of Governments with a policy to lower fertility rose from 47 per cent in 1976 to 63 per cent in 2001. While in 1976, nine countries viewing fertility as too high did not have any policy to modify it, in 2001, there were only two such countries (see tables 2 and 10). Countries with TFR between 3.5 and 5 children per woman are more likely to have a policy to lower fertility (68 per cent) than those with TFR between 2.1 and 3.5 children per woman (59 per cent) (see table 10).

Many countries have steadily had a policy to lower fertility throughout the entire post-Bucharest period: 9 of 13 countries in Africa (70 per cent), and one third of countries in Asia and Oceania and in Latin America and the Caribbean. In the 1990s, fourteen countries shifted from a policy of non-intervention to one aimed at lowering fertility: Cape Verde and Sudan in Africa; Bahrain, Iran, Jordan, Lebanon and Papua New Guinea in Asia and

Oceania; and Bahamas, Colombia, Costa Rica, Ecuador, Guatemala, Nicaragua and Venezuela in Latin America and the Caribbean. Malaysia also shifted to this policy from one of maintaining fertility.

As a result, by 2001, all intermediate fertility countries in Africa, except Libyan Arab Jamahiriya, 54 per cent of those in Asia and Oceania, and 60 per cent in Latin America and the Caribbean had policies to reduce fertility.

The situation is particularly diverse in Latin America and the Caribbean. In the Caribbean and Central America, all countries (with the exception of Belize and Panama) have a policy to reduce fertility, but in South America only 40 per cent of countries do (Colombia, Ecuador, Paraguay, Peru and Venezuela), and Uruguay has a policy to raise it. Half of the countries in South America have steadily had a policy of non-intervention: Bolivia, Brazil, Chile, Guyana and Suriname. In addition, Argentina has had a policy of non-intervention since the 1980s.

The Governments of Israel and Uruguay have a policy to raise fertility. And the Government of the United Arab Emirates, after shifting to a policy of non-intervention in the 1990s, has recently returned to one of raising fertility, providing incentives for childbearing for national women.

Many countries have reported that they had adopted quantitative targets with regard to fertility levels. Botswana, for example, seeks to reduce TFR from 4 children per woman in 1996 to 3.4 in 2011. Ghana has a target to reduce TFR to 4 children per woman by 2010 and 3 children by 2020. Kenya set targets to reduce TFR to 3.5 children by 2005 and 2.5 by 2010. Bangladesh seeks to reduce TFR to 2.6 in 2002 and 2.2 in 2005. Indonesia wishes to reach replacement level fertility in 2005-2010, and India aims to do it by 2010.

In the 1990s, of all Governments with intermediate fertility who responded to the Inquiry, all in Africa and almost all in Asia (with exception of Israel and Tajikistan) reported that their policies in regard to fertility were adopted both to modify population growth and to improve family well-being. In contrast, eight Governments in Latin America and the Caribbean (Bahamas, Bolivia, Brazil, Costa Rica, Honduras, Nicaragua, Panama and Peru) and two in Asia and Oceania (Tajikistan and Fiji) pointed out that the chief objective in modifying the fertility level was to improve family well-being, and not to modify the rate of population growth.

2. Family planning and its integration with reproductive health programmes

Family planning has long been a core element of population policies and programmes and is a central component of reproductive health. Since the World Population Conference at Bucharest in 1974, Government policies have shifted in the direction of increased support for services providing modern, effective contraceptive methods. At the 1994 International Conference on Population and Development in Cairo, Governments have particularly reaffirmed the right of couples and individuals to choose the number and timing of children and to have access to the information and means to do so. Many Governments support family planning as part of basic reproductive health services.

Government support for policies and programmes that affect fertility has steadily increased in the intermediate fertility countries as well. In 2001, 94 per cent of those countries provided either direct (through governmental outlets), or indirect support (non-governmental sources) for family planning programmes and contraceptives (see table 11). The proportion of intermediate fertility countries providing direct support through state agencies was 87 per cent, slightly higher than in the less developed regions on a whole (84 per cent). The Government of Mongolia since 1988 has removed all restrictions with regard to the use, distribution and importation of contraceptives and began to widely provide modern contraception and educational programmes for women at risk. The Government of Albania since 1990s has also removed limitations on the scale and distribution of contraceptives and established a national family planning programme. Some countries previously providing no support for family planning have started to provide direct support (Qatar) or indirect support (Argentina, Belize and Kuwait). And eight countries (Bahamas, Bolivia, Colombia, Islamic Republic of Iran, Jordan, Myanmar, Nicaragua and Paraguay) have recently shifted from indirect to direct support for family planning.

In contrast, Israel has shifted from direct to indirect support, joining the Government of Lebanon, which has been steadily providing only indirect support for family planning. In 2001, only four of the Governments from

intermediate fertility countries still provide no support for family planning (Brunei Darussalam, Libyan Arab Jamahiriya, Turkmenistan and United Arab Emirates).

A number of Governments have identified national quantitative targets relative to contraceptive use. Botswana seeks to increase contraceptive prevalence from 42.5 per cent in 1996 to 65 per cent in 2011. Ghana aims to achieve the level of 28 per cent for modern methods by 2010 and 50 per cent by 2020. Bangladesh seeks to attain the contraceptive prevalence of 68 per cent by 2005 and 72 per cent by 2010. And Indonesia aims to reach 70 per cent of eligible couples by 2005.

To modify their fertility levels, Governments have used both direct and indirect measures. In earlier family planning programmes, some Governments emphasized direct measures, establishing norms on the number of children and the spacing between them, using incentives and disincentives, and targets for particular contraceptive methods. The leading type of incentive among countries seeking to lower the growth rate has been provision of free or subsidized contraceptives or services. Sterilization, IUDs, pills, condoms, and other methods are provided free of cost.

In some countries, cash incentives have been given to acceptors of sterilization operations, IUD acceptors and to motivators (referral agents). Many Governments have introduced a variety of disincentives, with measures such as imposition of an extra tax, limiting paid maternity leave, or adjusting priority in housing or employment.

The Government of Viet Nam, promoting a family of 1-2 children, used incentives and disincentives to encourage lower fertility. Among the incentives were provision of land and free contraception. Among disincentives were fines or job penalties. In 1988, the Government issued a Decision (Decree) concerning a number of population and family planning policies. It included the permitted numbers of children for different categories of population, and policies and regulations encouraging family planning. One of the standards to be considered in the allocation of land for the construction of a house and the distribution of housing was that the family should have two or fewer children. Families that had more than a certain number had to pay a housing or land rent calculated at a high price for the extra space they requested. They also had to contribute social support funds. People with three or more children were not permitted to move into the urban centers of municipalities, cities, and industrial zones. Moreover, when examining the results of the implementation of their plan, state agencies as well as production and business units were to give consideration to meeting the norms on population and family planning. The National Assembly passed the Health Law in 1989, which emphasized that couples are free to choose any available method of family planning and reiterated the voluntary nature of the population programme.

Currently, the Government of India offers retirement benefits for families having a limited number of children. A disincentive has been proposed to limit maternity leave to pregnant women with no more than two children. The Government of Iran passed a national family law in 1993 that encouraged couples to have fewer children by restricting maternity leave benefits after three children. In the Philippines, maternity leave is granted only for the first four children. In Nepal, tax exemptions are based on the number of children. Indonesia has adopted tax disincentives and income-generating activities for acceptors of family planning.

Sterilization has become the method most often subject to legal and administrative restrictions. Many countries in less developed regions once prohibited sterilization for contraceptive purposes. Recently, there has been a trend among countries to reduce or remove restrictions on voluntary sterilization. However, some Governments set age, parity, and other restrictions on those who may obtain voluntary sterilization. Governments impose restrictions on women more frequently than on men.

Targets were an integral part of the family planning programme in many countries for decades. Annual targets for different methods, imposed from the top down, were set for family planning workers at all levels, and their performance was judged in terms of the fulfillment of the targets.

The ICPD Programme of Action emphasized that all countries should, over the next several years, assess the extent of the national unmet need for quality family-planning services and their integration into the reproductive health context, paying particular attention to the most vulnerable and underserved groups in the population. Many

countries, particularly in Africa and Asia, reported in the Eighth Inquiry that they had attempted to assess unmet needs for family planning among the most vulnerable groups.

Following the Cairo Conference, many Governments have drafted new laws and strategy documents, have taken concrete policy actions toward the goal of providing universal access to reproductive health care. In some countries, these actions included developing comprehensive national reproductive health policies. In others, Governments redesigned aspects of national family planning or health programmes to address reproductive health. In the 1990s, new national population policies and programmes were adopted in many intermediate fertility countries such as Viet Nam (1993); Bangladesh, Ghana, Malaysia, Turkey (1994); El Salvador and Nicaragua (1997); and India (2000). Their main objectives were to ensure the achievement of sustainable growth and development. For this purpose, many national policies are aimed at reducing the population growth rate. Following the adoption of the ICPD Programme of Action, many Governments have been revising their national population policies, and health policies in particular. They have also been integrating family planning with comprehensive reproductive health care within general health policies.

The “MCH” approach has been the key policy initiative of India since the 1960s, although in 1996, the requisite coordination for integrating maternal and child health and family planning was still considered a goal to be achieved in the country. India’s 2000 national population policy also calls for integrated service delivery of basic reproductive and child health care. The still continuing high rate of mortality under age 5 in India (99 per 1,000 births in 1995-2000) is an important factor of a slowing fertility transition.

The Government of India in 1996 decided to re-orient its Family Welfare Programme and to replace it with the new Reproductive and Child Health Programme. The Programme’s objective is to improve the quality, coverage, effectiveness and access to services. The target approach has also been changed and the health workers do not have to meet pre-determined targets. Instead, they are to be a part of the planning process to plan their own workload for service provision. The practice of setting centrally determined contraceptive method-related performance targets was ended and replaced by a system of community needs assessment to drive the Programme. Guidelines for sterilization and contraceptive administration have been revised. Sterilizations are available only to married and cohabiting persons, preferably with at least one child aged more than one year. While IUDs are encouraged only for women with children, pills and condoms are freely available. The reproductive and child health programme provides for a substantial step up in investment of resources in infrastructure, services and information in the public sector, for delivery free of cost. The RCH programme contains special measures for tribal areas and urban slums, including infrastructure improvement.

Malaysia also no longer follows a target-oriented approach in the provision of family planning services. In Bangladesh, the Government policy involves prevention of unsafe abortion, training for the relevant service providers, and promotion of effective contraceptive methods, and decrease in unwanted pregnancies. Community clinics are being established to deliver essential services packages. In South Africa, a new 1996 Constitution included universal rights to reproductive choice and reproductive care, to be implemented in a reorganized health system that provides free primary health care for women and for children under age 6.

Strategies for improving the quality of care have been the focus of the Government of Ghana. Health service providers are being trained in pre-service and in-service programmes to acquire the requisite knowledge and skills in reproductive health to help improve and expand services at all levels of service delivery. The roles of the mid-wife and other partners in both private and public sectors are being expanded on a more regular basis. Midwives and other providers are being trained in life-saving skills.

The Government of Kenya has formulated a national population policy for sustainable development. A National Reproductive Health Strategy (1997-2010) has also been developed. The Government promotes cooperation and collaboration at all levels of programme implementation. Provincial and district health management teams have been established. Training for the service providers is being organized. Male-only clinics have been opened. In responses to the Eighth Inquiry, the Government of Kenya noted that the implementation of its Programme of Action had encountered obstacles related to illiteracy, poverty, and cultural and religious factors. Moreover, the allocated resources for the programme are considered to be inadequate.

The Government of Nepal has adopted policies on fertility and reproductive health. They include raising a large-scale demand for small families by creating the social and economic environment favourable to families with two children; implementing family planning programmes in an integrated manner with other health activities. The Government strategy includes the expansion of health and hospital services and of out-reach service delivery; and promotion of non-government and private organizations which can improve the delivery of family planning services. To reduce child mortality, the Government has set targets to offer different kinds of immunization to many millions of children.

One of the most serious issues of reproductive health is abortion. In some countries, abortion rates have reached high levels (see table 7). In Viet Nam, they were over 80 per 1,000 women aged 15-44 in mid-1990s and though decreasing they still were reported over 60 in 1999. In Turkmenistan, abortion rates were in the range of 30 to 40 per 1,000 in the 1990s. However, the Government of Turkmenistan provides no support for family planning programmes and contraceptives. Obviously, in such countries, women rely heavily on abortion to limit their fertility. For example, in Viet Nam, at least 4 pregnancies in 10 are aborted. In India, where abortion is permitted on health grounds as well as for contraceptive failure on the part of married woman or her husband, it is believed that many legal abortions are not reported and that a large number of illegal and unsafe abortions are performed. According to official statistics, the number of legal abortions was 566,000 in 1995-1996, although the actual numbers are thought to be several times this figure.

Only a handful of recent estimates of the number of abortions are available in countries where abortion is highly restricted or illegal. The most recent estimates of abortion rates for Latin America and Caribbean countries are for 1989-1991 and are quite high in some countries: Brazil (41 per 1,000), Colombia (36 per 1,000), Dominican Republic (47 per 1,000) and Peru (56 per 1,000). In Mexico, the abortion rate was lower and stood at 25 per 1,000 women aged 15-44 (Henshaw and others, 1999; Singh and Wulf, 1994).

Information on induced abortions in sub-Saharan Africa is extremely fragmentary. Survey data suggest that in Africa, the majority of women having abortions are unmarried. In contrast, in countries of the former Soviet Union, most women having abortions are married, for example, over 95 per cent in Albania, Kyrgyzstan and Uzbekistan. All Asian and Latin American countries for which data are available display a similar pattern, with the exception of Brazil, where the majority of women having abortions are unmarried. Where the large majority of women having abortions are married, it appears that people rely upon abortion as a method—sometimes as the primary method—of fertility regulation.

In the 1990s, some intermediate fertility countries modified their laws and regulations concerning abortion and the performance of abortion. Botswana (1991) and South Africa (1996) significantly amended their existing legislation or enacted new abortion laws along a more liberal line. Sudan (1991) modified its Penal Code to allow abortion to be performed in case of rape, or if the unborn child has died in the mother's womb. In El Salvador, the new Penal Code, adopted in 1997, removed all exceptions to the prohibition against abortion that previously existed and prohibited abortions completely.

In Asia, recent developments include the enactment of abortion legislation that confirms to Islamic Law, for example in the Islamic Republic of Iran (1991 Criminal Code). Both Indonesia (1992) and Malaysia (1989) amended their legislation to allow abortion to be performed on medical grounds. Also in 1989, Mongolia amended its Health Law to provide that becoming a mother was a matter of a woman's own decision and therefore, she could obtain an abortion on request during the three first months of pregnancy. Between 1989 and 1991, the Government of Viet Nam approved a number of laws that regulated abortion in various ways including the Law on the Protection of Public Health which provided that "women shall be entitled to have an abortion if they so desire", as well as various decrees making birth control devices and public-health services for abortions free of charge to large segments of the population.

Abortion laws and policies are significantly more restrictive in the developing world than in the developed world. Only one in seven developing countries (21 countries) allows abortion upon request and only one in six countries allows abortion for economic or social reasons. Among the intermediate fertility countries, abortion is

permitted on request in only three countries of Africa: Cape Verde, South Africa and Tunisia, in eight countries of Asia and Oceania: Bahrain, Mongolia, Kyrgyzstan, Turkey, Turkmenistan, Viet Nam and Uzbekistan, only in Guyana in Latin America and the Caribbean as well as in Albania in Europe (see table 5). In India, with high rates of abortion, abortion is permitted on health grounds as well as for the reason of contraceptive failure on the part of a married woman or her husband. It is believed that many legal abortions are not reported and that a large number of illegal and unsafe abortions are also performed.

3. Special programmes for adolescents

During the 1990s, increased concern with teenage pregnancy and abortion led to shifting the policy emphasis to reaching out beyond the married population - the primary, and often the only target of family planning programmes. In 2001, of the 57 intermediate fertility countries for which information was available 42 (74 per cent) reported having adopted measures to address adolescent fertility, and some had adopted integrated programmes. In Africa, only four countries (Algeria, Cape Verde, Morocco and Sudan) and in Latin America and the Caribbean three countries (Belize, El Salvador and Suriname) did not report any special measures. In contrast, in Western Asia, only two countries have adopted such measures (Israel and Turkey).

Among the measures, most of the emphasis was put on information, education and communication. Education on reproductive health and family life is part of curriculums of public schools of many countries. Some Governments take initiatives to reach out-of-school youth. The Government of Bangladesh has established an information programme for adolescents on nutrition, hygiene, puberty, safer sex behavior, and risks of STD/HIV/AIDS. Youth centers and youth-friendly clinics have been established in Kenya.

In Ghana, an adolescent Health Desk has been set up in the Ministry of Health. Male motivational and innovative activities in family planning are being developed and pursued. Draft Policy on Adolescent Reproductive Health has been developed and widely disseminated. "Teen" clinics and Youth Centres in schools are being set up. Studies on adolescent sexuality of different dimensions are carried out and their results influence programme planning. Family life education programmes for in school and out-of-school youth are being promoted by both governmental and non-governmental organizations. Peer counseling programmes are also being pursued.

In Viet Nam, family planning information and services targeted mainly married women. Therefore, the Government has recently commenced adolescent health programmes (in general) and reproductive health services in particular. In addition, it has integrated population education into the public school curricula and currently is further strengthening and expanding it.

Young people often encounter barriers in standard health care facilities. Also, contraceptives are not permitted to adolescents regardless of their marital status in many developing countries, including Chile, Dominican Republic, Indonesia, Kenya, Malaysia, Myanmar and Papua New Guinea. In Bangladesh, there is a special programme for married adolescents and access to services is permitted to them, though there are no restrictions when it comes to purchasing contraceptives from the private sector. In Papua New Guinea, access to services for adolescents varies from province to province and from one cultural group to another. The early marriage of girls, especially those with little or no education, poses a great challenge for the Government. Formal education of girls ends with their marriage; thus, there is scope for information and education campaigns directed at both parents and young people. Although teenage pregnancy rates are high in Vanuatu, chiefs and families in villages often do not support the notion of making contraception available to unmarried couples or multi-sex partners because such behaviour is against cultural norms and values. As a result, a considerable number of unwanted pregnancies occur. One of the areas under serious consideration by Governments in some countries is sex education in the schools.

4. Information, advocacy and public participation in family planning and reproductive health programmes

Many Governments are increasingly realizing the importance of raising people's awareness with respect to family planning and reproductive health issues and providing their active participation in programmes.

In Indonesia, with about 90 per cent of the population adhering to the Islamic faith, the Government before launching the family planning programme tried to create a conducive atmosphere among the public for supporting the general concept and policy on curbing the population growth rate. The Government managed through mutual discussions and consultations with Islamic leaders, ulamas, to make them its allies who started to actively support the programme. Their support was essential for convincing the public of the need for a family planning and for the widespread use of different forms of contraception. Another feature of the family planning programme there has been the high level of community participation. There are millions of volunteers who devote time and energy to voluntary family planning and health work (Singh, 1994). The total fertility rate steadily decreased from over 5 children per woman in the 1970s to 2.6 children in the 1995-2000.

In the Islamic Republic of Iran, since 1989 the Government has reversed its policy to one to slow population growth and established a national family planning programme. Its major goal is the prevention of unwanted pregnancies in order for families to improve their physical and social health (Hoodfar, Homa and Samad Assadpour, 2000). The Government has incorporated information on population, family planning, and mother and child health care in curriculum materials and entrusted the media with broadcasting such information and raising awareness of population issues and family planning programmes. Religious leaders have become involved with promotion of smaller families, citing them as a social responsibility in their weekly sermons. They have issued fatwas, religious edicts that permit and encourage the use of all types of contraception, including permanent male and female sterilization. The Government has actively involved men in family planning, introduced mandatory premarital contraceptive counseling for couples before receiving a marriage license (Larsen, 2001). The 1993 national quantitative targets were for TFR of 4 children per woman and for the population growth rate of 2.3 per cent to be achieved within 20 years. However, TFR fell sharply from 5.5 in 1988 to below 2.8 in 1996, a 50 per cent decline in 6 years. The actual population growth rate went down also much faster—from 3.7 per cent in 1985-1990 to 2 per cent in 1990-1995 and 1.2 per cent in 2001, one of the fastest drops ever recorded.

In Viet Nam, though the population and family planning programme has existed since 1963, its activities were promoted with little success. The Government set a target to reduce the population growth rate to 2 per cent by 1980, but it was not achieved. A revised target was set to reduce the rate of population growth to 1.7 per cent by 1985. It was not achieved again and the Government was compelled to shift the target to the end of 1990s. In 1992, along with the adoption of a new Constitution and series of laws with regard to marriage and family, health care, and protection the Government approved a strategy for education regarding population and family planning. Its general objectives were to promote the acceptance of a small, healthy, happy, and prosperous family as the social norm by adequately providing information on population, development and family planning methods, and by mobilizing every member of the community to voluntarily participate in the population and family planning programme with a view to achieving the general population objectives of the country.

Population education has become a compulsory subject in all education levels, grades and faculties in Viet Nam. It has been also included in various forms of informal education such as elimination of illiteracy, complementary education, vocational training. The existing infrastructure of separate organizations for women, youth, peasants and workers as well as organizations of volunteers, such as the Red Cross, has been a good opportunity to infuse family planning throughout the country. The Fatherland Front- an umbrella organization that embraces all mass organizations and patriotic organizations as well as sectors representing the various religions- has been also involved in population activities. It has critical access to the various religions and has played an important role in mobilizing their support for the population and family planning programme. While the Government had targets to reach the total fertility rate of 3.1 children per woman by 2000 and 2.2 children by 2010, the fertility decline has occurred much faster, ahead of the Government's targets; it went down to 2.3 children per woman in the mid-1990s. The rate of population growth also went sharply down to 1.4 per cent in 1995-2000.

The Governments in many intermediate fertility countries have recently made a particular emphasis on the attraction of public participation and support in national population programmes. They have adopted measures to promote greater community participation in family planning and reproductive health services, to decentralize their management. NGOs and citizen activists, religious and community leaders and the private sector have been increasingly becoming active partners with Governments in deliberations on new policies and programmes as well as their implementation. And this has appeared as an important factor in the progress of their implementation.

In Mexico, the National Forum of Women and Population Policy, a network including over 70 women's organizations works closely with the Government and with the states to ensure that policies and services reflect the ICPD mandate (McDonald, 1999). In Morocco, the Government regularly consults with over 70 NGOs that work on issues related to women and development. In Brazil and South Africa, NGOs working on women's rights have played a prominent role in reshaping the national health agenda. In addition, in the conditions of increasing decentralization in many countries, NGOs and private sector often fill gaps in Government-supported services. In Bangladesh, decentralization has been one of the major reorganization issues in the country's new health and population-sector strategy. Botswana has established multidisciplinary committees that include communities, NGOs, and the private sector. In Ghana, district and subdistrict institutions are being given more autonomy in terms of resource allocation. The Government has set up a desk for coordinating private-sector collaborative activities in the Ministry of Health.

C. SOCIAL POLICIES AND FERTILITY

Many other social policies that Governments adopt can also have demographic effects. Among the examples are those related to education, employment and women's status.

Women's education and lower fertility rates are closely related (United Nations, 1995). Educated women have more access to paid work, marry later, want fewer children and have fewer unwanted children. They are also more likely to know about contraception, start using it earlier and rely on modern as opposed to traditional methods. Most countries under consideration have developed and implemented national comprehensive education strategies. Many Governments, for example Indonesia and Argentina, have set up a legal framework to ensure equal access to free and compulsory primary and secondary education for all children. Of particular interest is the schooling of girls and adolescent women. Many of the countries in Latin America illustrate cases of fully developed and integrated plans with clear implementation targets and mechanisms. In Brazil, education is a constitutional right and significant amounts of the public budget are allocated to education. A ten-year plan for Education for All was elaborated in 1993, and legislation in 1996 instituted the Decade for Education (UNESCO, 2001). Argentina has taken legal action to ensure equal access to free and compulsory education for periods up to 10 years. In Peru, laws were passed on women's right to education including the prohibition of expelling pregnant students. Also African countries have undertaken various efforts to improve education. Algeria and Tunisia are enforcing policies to improve educational attainment by favoring the opening of schools in rural and isolated areas. In addition, the government of Algeria has been implementing policies providing support for students from poorer families to cover transport and school fees (United Nations, 2000). In order to increase the educational level in the whole country, India has set up a National Committee of Education Ministers to plan and implement universal elementary education. In South-eastern Asia, the government of Indonesia is undertaking ambitious efforts to provide free primary and secondary education and to enforce school attendance more forcefully.

Government support for advanced education and increased participation in the formal labor market (see table 12) has brought more and more economic independence for women. Therefore, following similar patterns as women in the developed world, an increasing number of young women in developing countries, especially in urban areas, are delaying marriage. Over the past two decades, with increasing educational attainments, the global labor force has gradually evolved from a largely agricultural to an industrial and services oriented workforce. Urban life's greater employment and educational opportunities are more conducive to smaller families.

Several countries have adopted measures to protect working women and to improve working conditions for mothers. Particularly, since the Fourth World Conference on Women (Beijing, 1995), some countries have taken steps to bring their laws and policies into accord with international conventions. Examples include Algeria, Chile, Dominican Republic, Ghana, and Indonesia. Chile for example modified its Labour Code in 1998 to prohibit employers from discriminating against women, based on women's reproductive role, in their access to employment and promotion (United Nations, 2000). Some countries have adopted additional legislation to enforce international labour conventions. For example the right of a mother to maternity leave from her employment after childbirth, and a guarantee that she can return, has been recognized internationally since the ILO-Maternity Convention was adopted

in 1952 (United Nations, 2000). This Convention guarantees a standard maternity leave of at least 12 weeks duration. However, how such maternity leave is implemented, whether granting is optional or compulsory for the employer, and the percentage of wage paid can vary profoundly. In general, conditions are the least favourable in African countries and most advanced in Latin America. Some countries have adopted additional legislation to enforce international labour conventions.

D. CONCLUSION

This paper reviews the views and policies of Governments related to population growth and fertility for the currently intermediate fertility countries of the world. It also provides some information on social policies and social variables that can affect fertility levels as well as policies concerning family planning and contraceptive use.

The major points of this paper are:

- The majority of the intermediate fertility countries have had policies to reduce fertility during the past quarter century. Countries with higher fertility are more likely to have such a policy.
- The percentage of the intermediate fertility countries providing direct support for family planning has increased during the past twenty-five years.
- However, there is great diversity among the major areas of the world. Nearly all intermediate fertility countries in Africa, 54 per cent of those in Asia and Oceania, and 60 per cent in Latin America and the Caribbean have policies to reduce fertility.
- Some Governments have been using national quantitative targets for the population growth rate and for the total fertility rate, as well as national quantitative targets relative to contraceptive use. However, these Governments are increasingly shifting from the target approach to community needs assessment approach with an emphasis on clients' needs and improving the quality of care.
- Many Governments have been using incentives and disincentives to influence fertility levels. They include restrictions on maternity leaves, child and retirement benefits, tax exemptions based on the number of children; tax disincentives and income-generating activities for acceptors of family planning.
- Following the adoption of the Programme of Action of the International Conference on Population and Development, many Governments have been revising their national population policies, and health policies in particular. They have also been integrating family planning with comprehensive reproductive health care and within general health policies.
- In some intermediate fertility countries, women rely on abortion to limit their fertility. To address this issue, Governments are promoting reproductive health and expansion of contraceptive choice.
- Adolescent fertility is a growing concern for many Governments in intermediate fertility countries, particularly in Latin America and Caribbean, and in Africa. Consequently, Government programmes are reaching out beyond the married population.
- Many Governments are increasingly realizing the importance of raising people's awareness with respect to family planning and reproductive health issues and of active participation of civil society in the implementation of programmes. They have been adopting measures to promote greater community participation in family planning and reproductive health services and decentralize their management.
- Policies in the areas of employment, education, health, particularly child health, gender relations, and the advancement of women can affect the fertility level. Most of the intermediate fertility countries have been developing these policies, however, with varied intensity, prioritization and coverage.

TABLE 1. GOVERNMENT VIEWS AND POLICIES ON POPULATION GROWTH

Country	View on population growth				Policy to population growth			
	1976	1986	1996	2001	1976	1986	1996	2001
Africa								
Eastern Africa								
Kenya.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Northern Africa								
Algeria.....	Satisfactory	Too high	Too high	Too high	No intervention	Lower	Lower	Lower
Egypt.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Libyan Arab Jamahiriya.....	Too low	Satisfactory	Satisfactory	Satisfactory	Raise	No intervention	No intervention	No intervention
Morocco.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Sudan.....	Satisfactory	Satisfactory	Too high	Too high	No intervention	No intervention	Lower	Lower
Tunisia.....	Too high	Too high	Satisfactory	Satisfactory	Lower	Lower	Lower	Lower
Southern Africa								
Botswana.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Lesotho.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
South Africa.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Swaziland.....	Too high	Too high	Too high	Too high	Lower	No intervention	Lower	Lower
Western Africa								
Cape Verde.....	Satisfactory	Satisfactory	Too high	Too high	No intervention	No intervention	Lower	Lower
Ghana.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Asia								
Eastern Asia								
Mongolia.....	Too low	Too low	Satisfactory	Satisfactory	Raise	Raise	Maintain	Maintain
South-central Asia								
Bangladesh.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
India.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Iran (Islamic Republic of).....	Too high	Satisfactory	Too high	Too high	Lower	No intervention	Lower	Lower
Kyrgyzstan.....	..	..	Satisfactory	Satisfactory	..	..	No intervention	No intervention
Nepal.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Tajikistan.....	..	..	Satisfactory	Too high	..	..	No intervention	No intervention
Turkmenistan.....	..	..	Satisfactory	Satisfactory	..	..	No intervention	No intervention
Uzbekistan.....	..	..	Too high	Satisfactory	..	..	Lower	Maintain
South-eastern Asia								
Brunei Darussalam.....	..	Satisfactory	Satisfactory	Satisfactory	..	No intervention	No intervention	No intervention
Indonesia.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower

TABLE 1 (continued)

Country	View on population growth				Policy to population growth			
	1976	1986	1996	2001	1976	1986	1996	2001
Malaysia.....	Too high	Satisfactory	Too high	Satisfactory	Lower	Maintain	Lower	No intervention
Myanmar.....	Satisfactory	Satisfactory	Satisfactory	Satisfactory	No intervention	No intervention	No intervention	No intervention
Philippines.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Viet Nam.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Western Asia								
Bahrain.....	Satisfactory	Satisfactory	Satisfactory	Satisfactory	No intervention	No intervention	No intervention	No intervention
Israel.....	Too low	Too low	Too low	Too low	Raise	Raise	Raise	Raise
Jordan.....	Satisfactory	Satisfactory	Too high	Too high	No intervention	No intervention	Lower	Lower
Kuwait.....	Too low	Too low	Satisfactory	Satisfactory	No intervention	Raise	Maintain	Maintain
Lebanon.....	Satisfactory	Satisfactory	Satisfactory	Satisfactory	No intervention	No intervention	No intervention	Maintain
Qatar.....	Too low	Too low	Too low	Satisfactory	Raise	Raise	Raise	Maintain
Syrian Arab Republic.....	Satisfactory	Satisfactory	Satisfactory	Satisfactory	No intervention	No intervention	No intervention	No intervention
Turkey.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
United Arab Emirates.....	Too low	Satisfactory	Too high	Too high	Raise	Raise	No intervention	No intervention
Europe								
Southern Europe								
Albania.....	Satisfactory	Satisfactory	Satisfactory	Satisfactory	No intervention	Maintain	Maintain	Maintain
Latin America and the Caribbean								
Caribbean								
Bahamas.....	Too low	Satisfactory	Satisfactory	Satisfactory	Raise	No intervention	No intervention	No intervention
Dominican Republic.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Haiti.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Jamaica.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Saint Lucia.....	..	Too high	Too high	Too high	..	Lower	Lower	Lower
Central America								
Belize.....	..	Satisfactory	Too low	Satisfactory	..	No intervention	No intervention	No intervention
Costa Rica.....	Too high	Satisfactory	Too high	Satisfactory	No intervention	No intervention	Lower	No intervention
El Salvador.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Guatemala.....	Too high	Too high	Satisfactory	Too high	No intervention	No intervention	No intervention	Lower
Honduras.....	Satisfactory	Too high	Satisfactory	Satisfactory	No intervention	Lower	No intervention	No intervention
Mexico.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Nicaragua.....	Too high	Satisfactory	Too high	Too high	No intervention	No intervention	Lower	Lower
Panama.....	Satisfactory	Satisfactory	Satisfactory	Satisfactory	No intervention	No intervention	No intervention	Maintain
South America								

TABLE 1 (continued)

Country	View on population growth				Policy to population growth			
	1976	1986	1996	2001	1976	1986	1996	2001
Argentina.....	Too low	Satisfactory	Satisfactory	Satisfactory	Raise	No intervention	No intervention	No intervention
Bolivia.....	Satisfactory	Too low	Satisfactory	Satisfactory	No intervention	No intervention	No intervention	No intervention
Brazil.....	Satisfactory	Satisfactory	Satisfactory	Satisfactory	No intervention	No intervention	No intervention	No intervention
Chile.....	Satisfactory	Too low	Satisfactory	Satisfactory	No intervention	No intervention	No intervention	No intervention
Colombia.....	Too high	Satisfactory	Satisfactory	Satisfactory	Lower	No intervention	No intervention	No intervention
Ecuador.....	Too high	Satisfactory	Satisfactory	Satisfactory	No intervention	No intervention	No intervention	No intervention
Guyana.....	Satisfactory	Satisfactory	Satisfactory	Satisfactory	No intervention	No intervention	No intervention	No intervention
Paraguay.....	Too low	Satisfactory	Satisfactory	Too high	No intervention	No intervention	No intervention	Lower
Peru.....	Satisfactory	Too high	Too high	Too high	No intervention	Lower	Lower	Lower
Suriname.....	Satisfactory	Satisfactory	Satisfactory	Satisfactory	No intervention	No intervention	No intervention	No intervention
Uruguay.....	Too low	Too low	Too low	Too low	Raise	No intervention	Raise	Raise
Venezuela.....	Satisfactory	Satisfactory	Satisfactory	Satisfactory	No intervention	No intervention	No intervention	No intervention
Oceania								
Melanesia								
Fiji.....	Too high	Too high	Satisfactory	Satisfactory	Lower	Lower	Maintain	Maintain
Papua New Guinea.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Vanuatu.....	..	Satisfactory	Satisfactory	Satisfactory	..	No intervention	No intervention	No intervention
Polynesia								
Samoa.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower

Source: The Population Policy Databank maintained by the Population Division of the United Nations Secretariat.

TABLE 2. CHANGE IN GOVERNMENT VIEWS ON POPULATION GROWTH IN INTERMEDIATE FERTILITY COUNTRIES,
1976-2001, BY CURRENT LEVEL OF FERTILITY AND BY MAJOR AREA
(Percentage of countries)

<i>Countries</i>	<i>1976</i>				<i>2001</i>			
	<i>Too high</i>	<i>Satisfactory</i>	<i>Too low</i>	<i>Total</i>	<i>Too high</i>	<i>Satisfactory</i>	<i>Too low</i>	<i>Total</i>
Total	53	30	17	100	51	46	3	100
According to total fertility rate								
TFR 3.5-5.....	59	27	14	100	72	28	0	100
TFR 2.1-3.5.....	49	32	19	100	38	57	5	100
According to major area*								
Africa.....	69	23	8	100	85	15	0	100
Asia and Oceania.....	54	23	23	100	46	50	4	100
Latin America and the Caribbean.....	44	39	17	100	40	56	4	100

Source: The Population Policy Databank maintained by the Population Division of the United Nations Secretariat.
*Albania (Europe) is not included in the regional distribution.

TABLE 3. GOVERNMENT VIEWS AND POLICIES ON FERTILITY

Country	View on fertility level				Policy to modify fertility			
	1976	1986	1996	2001	1976	1986	1996	2001
Africa								
Eastern Africa								
Kenya.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Northern Africa								
Algeria.....	Satisfactory	Too high	Too high	Too high	No intervention	Lower	Lower	Lower
Egypt.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Libyan Arab Jamahiriya.....	Too low	Satisfactory	Satisfactory	Satisfactory	Raise	No intervention	No intervention	No intervention
Morocco.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Sudan.....	Satisfactory	Satisfactory	Too high	Too high	No intervention	No intervention	Lower	Lower
Tunisia.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Southern Africa								
Botswana.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Lesotho.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
South Africa.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Swaziland.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Western Africa								
Cape Verde.....	Satisfactory	Satisfactory	Too high	Too high	No intervention	No intervention	Lower	Lower
Ghana.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Asia								
Eastern Asia								
Mongolia.....	Satisfactory	Too low	Satisfactory	Satisfactory	Maintain	Raise	Maintain	No intervention
South-central Asia								
Bangladesh.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
India.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Iran (Islamic Republic of).....	Too high	Satisfactory	Too high	Too high	Lower	No intervention	Lower	Lower
Kyrgyzstan.....	..	..	Satisfactory	Satisfactory	..	..	No intervention	No intervention
Nepal.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Tajikistan.....	..	..	Too high	Too high	..	..	Lower	No intervention
Turkmenistan.....	..	..	Satisfactory	Satisfactory	..	..	No intervention	No intervention
Uzbekistan.....	..	..	Satisfactory	Satisfactory	..	..	Maintain	Maintain
South-eastern Asia								
Brunei Darussalam.....	..	Satisfactory	Satisfactory	Satisfactory	..	No intervention	No intervention	No intervention

TABLE 3 (continued)

Country	View on fertility level				Policy to modify fertility			
	1976	1986	1996	2001	1976	1986	1996	2001
Indonesia.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Malaysia.....	Too high	Satisfactory	Too high	Too high	Lower	Maintain	Lower	Lower
Myanmar.....	Satisfactory	Satisfactory	Too high	Satisfactory	No intervention	No intervention	No intervention	Maintain
Philippines.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Viet Nam.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Western Asia								
Bahrain.....	Too high	Satisfactory	Satisfactory	Satisfactory	No intervention	No intervention	Lower	Lower
Israel.....	Too low	Too low	Too low	Too low	Raise	Raise	Raise	Raise
Jordan.....	Too high	Satisfactory	Too high	Too high	No intervention	No intervention	Lower	Lower
Kuwait.....	Satisfactory	Too low	Satisfactory	Satisfactory	Maintain	Raise	Maintain	No intervention
Lebanon.....	Satisfactory	Satisfactory	Satisfactory	Satisfactory	No intervention	No intervention	No intervention	Lower
Qatar.....	Satisfactory	Satisfactory	Satisfactory	Satisfactory	Maintain	Maintain	Maintain	Maintain
Syrian Arab Republic.....	Satisfactory	Satisfactory	Satisfactory	Satisfactory	No intervention	No intervention	No intervention	No intervention
Turkey.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
United Arab Emirates.....	Satisfactory	Satisfactory	Satisfactory	Too low	Maintain	Raise	No intervention	Raise
Europe								
Southern Europe								
Albania.....	Satisfactory	Satisfactory	Satisfactory	Satisfactory	Maintain	Maintain	Maintain	Maintain
Latin America and the Caribbean								
Caribbean								
Bahamas.....	Satisfactory	Satisfactory	Satisfactory	Too high	No intervention	No intervention	No intervention	Lower
Dominican Republic.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Haiti.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Jamaica.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Saint Lucia.....	..	Too high	Too high	Too high	..	Lower	Lower	Lower
Central America								
Belize.....	..	Satisfactory	Too high	Satisfactory	..	No intervention	No intervention	No intervention
Costa Rica.....	Too high	Satisfactory	Too high	Satisfactory	No intervention	No intervention	Lower	Lower
El Salvador.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Guatemala.....	Too high	Satisfactory	Too high	Too high	No intervention	No intervention	Lower	Lower
Honduras.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Mexico.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower
Nicaragua.....	Too high	Satisfactory	Too high	Too high	No intervention	No intervention	Lower	Lower

TABLE 3 (continued)

Country	View on fertility level				Policy to modify fertility			
	1976	1986	1996	2001	1976	1986	1996	2001
Panama	Too high	Satisfactory	Satisfactory	Satisfactory	No intervention	No intervention	No intervention	Maintain
South America								
Argentina.....	Too low	Satisfactory	Satisfactory	Satisfactory	Raise	No intervention	No intervention	No intervention
Bolivia.....	Satisfactory	Too low	Satisfactory	Satisfactory	No intervention	No intervention	No intervention	No intervention
Brazil.....	Satisfactory	Satisfactory	Satisfactory	Satisfactory	No intervention	No intervention	No intervention	No intervention
Chile.....	Too high	Too low	Satisfactory	Satisfactory	No intervention	No intervention	No intervention	No intervention
Colombia.....	Too high	Satisfactory	Satisfactory	Satisfactory	Lower	No intervention	No intervention	Lower
Ecuador.....	Too high	Satisfactory	Too high	Too high	No intervention	No intervention	Lower	Lower
Guyana.....	Satisfactory	Satisfactory	Satisfactory	Satisfactory	No intervention	No intervention	No intervention	No intervention
Paraguay.....	Satisfactory	Satisfactory	Satisfactory	Too high	No intervention	No intervention	No intervention	Lower
Peru.....	Satisfactory	Too high	Too high	Too high	No intervention	Lower	Lower	Lower
Suriname.....	Satisfactory	Satisfactory	Satisfactory	Satisfactory	No intervention	No intervention	No intervention	No intervention
Uruguay.....	Too low	Too low	Too low	Too low	Raise	No intervention	Raise	Raise
Venezuela.....	Satisfactory	Satisfactory	Satisfactory	Satisfactory	No intervention	No intervention	Lower	Lower
Oceania								
Melanesia								
Fiji.....	Too high	Too high	Too high	Satisfactory	Lower	Lower	Lower	Lower
Papua New Guinea	Too high	Too high	Too high	Too high	Lower	No intervention	Lower	Lower
Vanuatu.....	..	Satisfactory	Satisfactory	Satisfactory	..	No intervention	No intervention	No intervention
Polynesia								
Samoa.....	Too high	Too high	Too high	Too high	Lower	Lower	Lower	Lower

Source: The Population Policy Databank maintained by the Population Division of the United Nations Secretariat.

TABLE 4. CHANGE IN GOVERNMENT VIEWS ON FERTILITY IN INTERMEDIATE FERTILITY COUNTRIES, 1976-2001,

BY CURRENT LEVEL OF FERTILITY AND BY MAJOR AREA

(Percentage of countries)

<i>Countries</i>	<i>1976</i>				<i>2001</i>			
	<i>Too high</i>	<i>Satisfactory</i>	<i>Too low</i>	<i>Total</i>	<i>Too high</i>	<i>Satisfactory</i>	<i>Too low</i>	<i>Total</i>
Total	61	32	7	100	57	39	4	100
According to total fertility rate								
TFR 3.5-5	68	27	5	100	76	24	0	100
TFR 2.1-3.5	57	35	8	100	45	48	7	100
According to major area*								
Africa	69	23	8	100	92	8	0	100
Asia and Oceania	64	32	4	100	46	46	7	100
Latin America and the Caribbean	56	35	9	100	52	44	4	100

Source: The Population Policy Databank maintained by the Population Division of the United Nations Secretariat.

* Albania (Europe) is not included in the regional distribution.

TABLE 5. TRENDS AND GOVERNMENT ACCEPTABILITY OF UNDER-FIVE MORTALITY

<i>Country</i>	<i>1975</i>	<i>2000</i>	<i>Annual percentage change, 1970-1975 to 1995-2000</i>	<i>Acceptability of under-five mortality 2001</i>
Africa				
Eastern Africa				
Kenya	169	109	-1.8	Unacceptable
Northern Africa				
Algeria	159	56	-4.2	Unacceptable
Egypt	210	64	-4.8	Unacceptable
Libyan Arab Jamahiriya	140	31	-6.0	Unacceptable
Morocco	179	68	-3.9	Unacceptable
Sudan	233	137	-2.1	Unacceptable
Tunisia	156	37	-5.8	Unacceptable
Southern Africa				
Botswana	152	135	-0.5	Unacceptable
Lesotho	221	159	-1.3	Unacceptable
South Africa	109	83	-1.1	Unacceptable
Swaziland	226	143	-1.8	Unacceptable
Western Africa				
Cape Verde	108	64	-2.1	Unacceptable
Ghana	177	112	-1.8	Unacceptable
Asia				
Eastern Asia				
Mongolia	152	99	-1.7	Unacceptable
South-central Asia				
Bangladesh	225	111	-2.8	Unacceptable
India	192	99	-2.6	Unacceptable
Iran (Islamic Republic of)	166	53	-4.6	Unacceptable
Kyrgyzstan	74	54	-1.3	Unacceptable
Nepal	241	117	-2.9	Unacceptable
Tajikistan	109	80	-1.2	Unacceptable
Turkmenistan	113	77	-1.5	Unacceptable
Uzbekistan	109	58	-2.5	Unacceptable
South-eastern Asia				
Brunei Darussalam	59	11	-6.7	Acceptable
Indonesia	185	63	-4.3	Unacceptable
Malaysia	57	15	-5.3	Acceptable
Myanmar	198	142	-1.3	Unacceptable
Philippines	112	42	-3.9	Unacceptable
Viet Nam	174	56	-4.5	Acceptable
Western Asia				
Bahrain	76	22	-5.0	Unacceptable
Israel	53	10	-6.7	Acceptable
Jordan	106	33	-4.7	Unacceptable
Kuwait	59	15	-5.5	Acceptable
Lebanon	60	23	-3.8	Acceptable
Qatar	64	16	-5.5	Acceptable
Syrian Arab Republic	118	32	-5.2	Acceptable
Turkey	194	60	-4.7	Unacceptable
United Arab Emirates	85	16	-6.7	Acceptable

TABLE 5 (continued)

<i>Country</i>	<i>1975</i>	<i>2000</i>	<i>Annual percentage change, 1970-1975 to 1995-2000</i>	<i>Acceptability of under-five mortality 2001</i>
Europe				
Southern Europe				
Albania	92	40	-3.3	Unacceptable
Latin America and the Caribbean				
Caribbean				
Bahamas	46	25	-2.4	Unacceptable
Dominican Republic	135	58	-3.4	Unacceptable
Haiti	194	115	-2.1	Unacceptable
Jamaica	56	27	-2.9	Acceptable
Saint Lucia	53	18	-4.3	Unacceptable
Central America				
Belize	70	42	-2.0	Unacceptable
Costa Rica	64	15	-5.8	Acceptable
El Salvador	152	41	-5.2	Unacceptable
Guatemala	165	61	-4.0	Unacceptable
Honduras	163	55	-4.3	Unacceptable
Mexico	100	38	-3.9	Unacceptable
Nicaragua	152	50	-4.4	Unacceptable
Panama	68	28	-3.5	Unacceptable
South America				
Argentina	58	25	-3.4	Acceptable
Bolivia	245	88	-4.1	Unacceptable
Brazil	126	49	-3.8	Unacceptable
Chile	81	15	-6.7	Acceptable
Colombia	101	39	-3.8	Unacceptable
Ecuador	137	60	-3.3	Unacceptable
Guyana	106	75	-1.4	Unacceptable
Paraguay	72	48	-1.6	Unacceptable
Peru	169	65	-3.8	Unacceptable
Suriname	58	33	-2.3	Unacceptable
Uruguay	52	20	-3.8	Unacceptable
Venezuela	67	25	-3.9	Unacceptable
Oceania				
Melanesia				
Fiji	66	24	-4.0	Acceptable
Papua New Guinea	161	96	-2.1	Unacceptable
Vanuatu	133	40	-4.8	Unacceptable
Polynesia				
Samoa	89	37	-3.5	Unacceptable

Source: The Population Policy Databank maintained by the Population Division of the United Nations Secretariat.

TABLE 6. MATERNAL MORTALITY RATIOS AND GOVERNMENT ACCEPTABILITY OF MATERNAL MORTALITY

<i>Country</i>	<i>Maternal mortality ratio</i>	<i>Acceptability of</i>
	<i>(per 100,000 births)</i>	<i>maternal mortality</i>
	1995	2001
Africa		
Eastern Africa		
Kenya	1300	Unacceptable
Northern Africa		
Algeria.....	150	Unacceptable
Egypt.....	170	Unacceptable
Libyan Arab Jamahiriya.....	120	Unacceptable
Morocco.....	390	Unacceptable
Sudan	1500	Unacceptable
Tunisia.....	70	Unacceptable
Southern Africa		
Botswana.....	480	Unacceptable
Lesotho.....	530	Unacceptable
South Africa.....	340	Unacceptable
Swaziland.....	370	Unacceptable
Western Africa		
Cape Verde.....	190	..
Ghana	590	Unacceptable
Asia		
Eastern Asia		
Mongolia.....	65	Unacceptable
South-central Asia		
Bangladesh	600	Unacceptable
India.....	440	Unacceptable
Iran (Islamic Republic of).....	130	Unacceptable
Kyrgyzstan.....	80	Unacceptable
Nepal.....	830	Unacceptable
Tajikistan.....	120	Unacceptable
Turkmenistan.....	65	Unacceptable
Uzbekistan.....	60	Unacceptable
South-eastern Asia		
Brunei Darussalam.....	22	Acceptable
Indonesia.....	470	Unacceptable
Malaysia.....	39	Unacceptable
Myanmar.....	170	Unacceptable
Philippines.....	240	Unacceptable
Viet Nam.....	95	Unacceptable
Western Asia		
Bahrain.....	38	Unacceptable
Israel.....	8	Acceptable
Jordan.....	41	Unacceptable
Kuwait.....	25	Acceptable
Lebanon.....	130	Acceptable
Qatar.....	41	Acceptable
Syrian Arab Republic.....	200	Acceptable
Turkey.....	55	Unacceptable

TABLE 6 (continued)

<i>Country</i>	<i>Maternal mortality ratio (per 100,000 births)</i>	<i>Acceptability of maternal mortality</i>
	1995	2001
United Arab Emirates.....	30	Acceptable
Europe		
Southern Europe		
Albania.....	31	Unacceptable
Latin America and the Caribbean		
Caribbean		
Bahamas.....	10	Acceptable
Dominican Republic.....	110	Unacceptable
Haiti.....	1100	Unacceptable
Jamaica.....	120	Acceptable
Saint Lucia.....	..	..
Central America		
Belize.....	140	Unacceptable
Costa Rica.....	35	Acceptable
El Salvador.....	180	Unacceptable
Guatemala.....	270	Unacceptable
Honduras.....	220	Unacceptable
Mexico.....	65	Unacceptable
Nicaragua.....	250	Unacceptable
Panama.....	100	Unacceptable
South America		
Argentina.....	85	Acceptable
Bolivia.....	550	Unacceptable
Brazil.....	260	Unacceptable
Chile.....	33	Acceptable
Colombia.....	120	Unacceptable
Ecuador.....	210	Unacceptable
Guyana.....	150	Unacceptable
Paraguay.....	170	Unacceptable
Peru.....	240	Unacceptable
Suriname.....	230	..
Uruguay.....	50	Unacceptable
Venezuela.....	43	Unacceptable
Oceania		
Melanesia		
Fiji.....	20	Acceptable
Papua New Guinea.....	390	Unacceptable
Vanuatu.....	32	Unacceptable
Polynesia		
Samoa.....	15	..

Source: The Population Policy Databank maintained by the Population Division of the United Nations Secretariat.

TABLE 7. ABORTION RATES AND GOVERNMENTS VIEWS AND POLICIES ON ABORTION

Country	Abortion rate (per 1,000 women aged 15-44)	Is induced abortion viewed as a matter of concern by the Government	Grounds on which abortion is permitted						On request	
			To save the woman's life	To preserve physical health	To preserve mental health	Rape or incest	Foetal impairment	Economic or social reasons		
Africa										
Eastern Africa										
Kenya.....	..	Yes	X	X	X	-	-	-	-	-
Northern Africa										
Algeria.....	..	No official position	X	X	X	-	-	-	-	-
Egypt.....	..	No official position	X	-	-	-	-	-	-	-
Libyan Arab Jamahiriya.....	..	..	X	-	-	-	-	-	-	-
Morocco.....	..	No	X	X	X	-	-	-	-	-
Sudan.....	..	No	X	-	-	X	-	-	-	-
Tunisia.....	9 (1996)	No	X	X	X	X	X	X	X	X
Southern Africa										
Botswana.....	..	Yes	X	X	X	X	X	-	-	-
Lesotho.....	..	..	X	-	-	-	-	-	-	-
South Africa.....	3 (1997)	No official position	X	X	X	X	X	X	X	X
Swaziland.....	..	..	X	-	-	-	-	-	-	-
Western Africa										
Cape Verde.....	..	..	X	X	X	X	X	X	X	X
Ghana.....	..	Yes	X	X	X	X	X	-	-	-
Asia										
Eastern Asia										
Mongolia.....	26 (1996)	Yes	X	X	X	X	X	X	X	X
South-central Asia										
Bangladesh.....	28 (1997) ^a	Yes	X	-	-	-	-	-	-	-
India.....	..	Yes	X	X	X	X	X	X	-	-
Iran (Islamic Republic of).....	..	No	X	-	-	-	-	-	-	-
Kyrgyzstan.....	16 (1999)	..	X	X	X	X	X	X	X	X
Nepal.....	..	No official position	X	-	-	-	-	-	-	-
Tajikistan.....	15 (1999)	No	X	X	X	X	X	X	X	X
Turkmenistan.....	32 (1997)	..	X	X	X	X	X	X	X	X
Uzbekistan.....	10 (1999)	..	X	X	X	X	X	X	X	X
South-eastern Asia										

TABLE 7 (continued)

Country	Abortion rate (per 1,000 women aged 15-44)	Is induced abortion viewed as a matter of concern by the Government	Grounds on which abortion is permitted							
			To save the woman's life	To preserve physical health	To preserve mental health	Rape or incest	Foetal impairment	Economic or social reasons	On request	
Brunei Darussalam	X	-	-	-	-	-	-	
Indonesia	Yes	X	-	-	-	-	-	-	
Malaysia	No official position	X	X	X	-	-	-	-	
Myanmar	Yes	X	-	-	-	-	-	-	
Philippines	Yes	X	-	-	-	-	-	-	
Viet Nam	63 (1999)	Yes	X	X	X	X	X	X	X	
Western Asia										
Bahrain	X	X	X	X	X	X	X	
Israel	15 (1999)	No	X	X	X	X	X	-	-	
Jordan	No	X	X	X	-	-	-	-	
Kuwait	Yes	X	X	X	-	X	-	-	
Lebanon	X	-	-	-	-	-	-	
Qatar	X	X	X	-	X	-	-	
Syrian Arab Republic	X	-	-	-	-	-	-	
Turkey	25 (1993)	No	X	X	X	X	X	X	X	
United Arab Emirates	X	-	-	-	-	-	-	
Europe										
Southern Europe										
Albania	22 (1999)	..	X	X	X	X	X	X	X	
Latin America and the Caribbean										
Caribbean										
Bahamas	No official position	X	X	X	-	-	-	-	
Dominican Republic	47 (1989/1991) ^b	No official position	X	-	-	-	-	-	-	
Haiti	X	-	-	-	-	-	-	
Jamaica	No official position	X	X	X	-	-	-	-	
Saint Lucia	No official position	X	X	X	-	-	-	-	
Central America										
Belize	Yes	X	X	X	-	X	X	-	
Costa Rica	Yes	X	X	X	-	-	-	-	
El Salvador	No official position	-	-	-	-	-	-	-	
Guatemala	X	-	-	-	-	-	-	
Honduras	No official position	X	-	-	-	-	-	-	

TABLE 7 (continued)

Country	Abortion rate (per 1,000 women aged 15-44)	Is induced abortion viewed as a matter of concern by the Government	Grounds on which abortion is permitted							
			To save the woman's life	To preserve physical health	To preserve mental health	Rape or incest	Foetal impairment	Economic or social reasons	On request	
Mexico.....	25 (1989/1991) ^b	Yes	X	-	-	X	-	-	-	
Nicaragua.....	..	Yes	X	-	-	-	-	-	-	
Panama.....	..	Yes	X	-	X	X	-	-	-	
South America										
Argentina.....	..	Yes	X	X	X	X	-	-	-	
Bolivia.....	..	Yes	X	X	X	X	-	-	-	
Brazil.....	41 (1989/1991) ^b	Yes	X	-	-	X	-	-	-	
Chile.....	50 (1989/1991) ^b	Yes	-	-	-	-	-	-	-	
Colombia.....	36 (1989/1991) ^b	Yes	X	-	-	-	-	-	-	
Ecuador.....	..	Yes	X	X	X	X	-	-	-	
Guyana.....	..	..	X	X	X	X	X	X	X
Paraguay.....	..	Yes	X	-	-	-	-	-	-	
Peru.....	56 (1989/1991) ^b	Yes	X	X	X	-	-	-	-	
Suriname.....	..	..	X	-	-	-	-	-	-
Uruguay.....	..	..	X	X	X	X	-	-	-
Venezuela.....	..	Yes	X	-	-	-	-	-	-	
Oceania										
Melanesia										
Fiji.....	..	Yes	X	X	X	-	-	X	-	
Papua New Guinea.....	..	Yes	X	X	X	-	-	-	-	
Vanuatu.....	..	..	X	X	X	-	-	-	-
Polynesia										
Samoa.....	..	..	X	X	X	-	-	-	-

Sources: The Population Policy Databank maintained by the Population Division of the United Nations Secretariat.

Singh, Susheela, Josefina V. Cabilon, Altaf Hossain, Haidey Kamal and Aurora E. Perez (1997). Estimating the Level of Abortion in the Philippines and Bangladesh. *International Family Planning Perspectives* (New York), Vol. 23, No. 3 (September).

Henshaw, Stanley, Susheela Singh, and Taylor Haas (1999b). Recent trends in abortion rate worldwide. *International Family Planning Perspectives* (New York), Vol. 25, No.1 (June).

TABLE 8. TEENAGE FERTILITY RATE, PERCENTAGE OF BIRTHS TO WOMEN UNDER AGE 20 AND GOVERNMENT VIEWS AND POLICIES ON ADOLESCENT FERTILITY

Country	Teenage fertility rate (per 1,000 women aged 15-19)	Percentage of births to women under age 20	Is adolescent fertility viewed as a matter of concern by the Government	Policies and programmes addressing adolescent fertility
Africa				
Eastern Africa				
Kenya.....	98	17	Major concern	Information, education and communication; youth centres and youth-friendly clinics.
Northern Africa				
Algeria.....	22	5	Minor concern	No
Egypt.....	52	10	Major concern	Yes
Libyan Arab Jamahiriya.....	19	4	..	..
Morocco.....	34	7	Minor concern	No
Sudan.....	64	9	Not a concern	No
Tunisia.....	12	3	Minor concern	Yes
Southern Africa				
Botswana.....	77	14	Major concern	Introducing friendlier health and family-planning facilities; use of peer educators to promote family planning.
Lesotho.....	74	11	Major concern	Yes
South Africa.....	81	17	Major concern	Yes
Swaziland.....	84	13	Not a concern	..
Western Africa				
Cape Verde.....	78	14	..	No
Ghana.....	91	15	Major concern	Family life education for in-school and out-of-school youth; peer counselling programmes.
Asia				
Eastern Asia				
Mongolia.....	57	13	Minor concern	National reproductive health programme.
South-central Asia				
Bangladesh.....	140	23	Major concern	Health and population programs for married adolescents; information for adolescents on nutrition, hygiene, puberty, safer sex behavior, and risks of STD/HIV/AIDS.
India.....	51	9	Major concern	Discouraging below legal age marriages; promotion of contraception and counselling, making abortion safer, care during pregnancy.
Iran (Islamic Republic of).....	38	9	Major concern	Yes
Kyrgyzstan.....	36	8	Not a concern	Yes
Nepal.....	136	19	Minor concern	Yes
Tajikistan.....	31	6	Not a concern	No
Turkmenistan.....	20	4	..	Yes
Uzbekistan.....	63	13	..	Yes
South-eastern Asia				
Brunei Darussalam.....	35	7	Not a concern	No
Indonesia.....	59	13	Major concern	Family life education.

TABLE 8 (continued)

Country	Teenage fertility rate (per 1,000 women aged 15-19)	Percentage of births to women under age 20	Is adolescent fertility viewed as a matter of concern by the Government	Policies and programmes addressing adolescent fertility
Malaysia.....	17	3	Major concern	National study on adolescent reproductive health and sexuality; provision of appropriate services for adolescents.
Myanmar.....	30	6	Major concern	Adolescent Reproductive Health Programme; life skills training for youth.
Philippines.....	45	8	Major concern	Population education for in-school youth; adolescent health and youth development programme.
Viet Nam.....	25	6	Minor concern	Adolescent health programmes; reproductive health services; population education for in-school youth;
Western Asia				
Bahrain.....	20	4	Not a concern	No
Israel.....	18	4	Minor concern	Family and sex education in schools.
Jordan.....	41	7	Not a concern	No
Kuwait.....	34	12	Not a concern	No
Lebanon.....	27	6	..	No
Qatar.....	26	4	..	No
Syrian Arab Republic.....	44	8	..	..
Turkey.....	64	14	Major concern	Adolescent Reproductive Health Programme.
United Arab Emirates.....	70	15	..	..
Europe				
Southern Europe				
Albania.....	16	3	..	No
Latin America and the Caribbean				
Caribbean				
Bahamas.....	63	14	Major concern	National adolescent health programme; family life education
Dominican Republic.....	97	20	Major concern	National programme of comprehensive assistance to adolescents; reproductive health educational programmes in and out of schools; education in print media.
Haiti.....	70	13	..	..
Jamaica.....	63	15	Major concern	Yes
Saint Lucia.....	73	17	Major concern	Yes
Central America				
Belize.....	94	19	Major concern	No
Costa Rica.....	85	18	Major concern	National programme of comprehensive assistance to adolescents, including social
El Salvador.....	95	19	Minor concern	No
Guatemala.....	119	18	Minor concern	Yes
Honduras.....	115	19	Minor concern	Health care programme for women; prevention of adolescent pregnancies.
Mexico.....	70	15	Major concern	Family planning programme; information, education and communication.
Nicaragua.....	157	25	Major concern	Yes
Panama.....	82	17	Major concern	Adolescent and women's health project; national programme of general health for schoolchildren and adolescents.
South America				

TABLE 8 (continued)

Country	Teenage fertility rate (per 1,000 women aged 15-19)	Percentage of births to women under age 20	Is adolescent fertility viewed as a matter of concern by the Government	Policies and programmes addressing adolescent fertility
Argentina.....	65	15	Major concern	Information, education and communication; counselling and reproductive health services
Bolivia.....	79	12	Minor concern	Yes
Brazil.....	72	18	Major concern	National programme of adolescent health assistance.
Chile.....	49	10	Major concern	Information, education and communication.
Colombia.....	88	18	Major concern	Sexual education plan; medical consultants for adolescents in local centres; information programs on adolescents pregnancy and prevention of pregnancy complications.
Ecuador.....	72	15	Major concern	Yes
Guyana.....	74	17	..	..
Paraguay.....	76	13	Minor concern	Information, education and communication on reproductive health; national plan for general health for adolescents.
Peru.....	58	12	Minor concern	Information, education and communication for youth and adolescents; sexual and family education, reproductive health and family-planning programme, school & adolescent health programme.
Suriname.....	21	6	Major concern	No
Uruguay.....	70	16	..	..
Venezuela.....	98	20	..	..
Oceania				
Melanesia				
Fiji.....	53	11	Minor concern	Creation of advocacy unit for adolescent health; introduction of emergency contraceptives.
Papua New Guinea.....	89	13	Minor concern	Free access to information; peer education programme.
Vanuatu.....	62	9	..	..
Polynesia				
Samoa.....	49	10	..	..

Source: The Population Policy Databank maintained by the Population Division of the United Nations Secretariat.

TABLE 9. CHANGE IN GOVERNMENT POLICIES ON POPULATION GROWTH IN INTERMEDIATE FERTILITY COUNTRIES,
1976-2001, BY CURRENT LEVEL OF FERTILITY AND BY MAJOR AREA
(Percentage of countries)

Countries	1976					2001				
	Lower	Maintain	Raise	No intervention	Total	Lower	Maintain	Raise	No intervention	Total
Total	46	0	13	41	100	49	12	3	36	100
According to total fertility rate										
TFR 3.5-5.....	50	0	9	41	100	68	4	0	28	100
TFR 2.1-3.5.....	43	0	16	41	100	38	17	5	40	100
According to major area*										
Africa.....	69	0	8	23	100	92	0	0	8	100
Asia and Oceania.....	55	0	18	27	100	39	21	4	36	100
Latin America and the Caribbean.....	26	0	13	61	100	40	4	4	52	100

Source: The Population Policy Databank maintained by the Population Division of the United Nations Secretariat.
* Albania (Europe) is not included in the regional distribution.

TABLE 10. CHANGE IN GOVERNMENT POLICIES ON FERTILITY IN INTERMEDIATE FERTILITY COUNTRIES,
1976-2001, BY CURRENT LEVEL OF FERTILITY AND BY MAJOR AREA
(Percentage of countries)

Countries	1976					2001				
	Lower	Maintain	Raise	No intervention	Total	Lower	Maintain	Raise	No intervention	Total
Total	47	9	7	37	100	63	7	5	25	100
According to total fertility rate										
TFR 3.5-5.....	54	5	5	36	100	68	4	0	28	100
TFR 2.1-3.5.....	43	11	8	38	100	59	10	8	24	100
According to major area*										
Africa.....	69	0	8	23	100	92	0	0	8	100
Asia and Oceania.....	54	18	5	23	100	54	11	7	28	100
Latin America and the Caribbean.....	30	0	9	61	100	60	4	4	32	100

Source: The Population Policy Databank maintained by the Population Division of the United Nations Secretariat.
* Albania (Europe) is not included in the regional distribution.

TABLE 11. TRENDS IN PERCENTAGE OF MARRIED WOMEN USING CONTRACEPTION, AND GOVERNMENT POLICIES ON PROVIDING ACCESS TO CONTRACEPTIVE METHODS

Country	Percentage of women using contraception			Trends (1990-2000) Annual increase in percentage using		Policy to provide access to contraceptive methods			
	Year	Any method	Modern methods	Any method	Modern methods	1976	1986	1996	2001
<i>Africa</i>									
<i>Eastern Africa</i>									
Kenya.....	2000	39	32	1.3	1.3	Direct support	Direct support	Direct support	Direct support
<i>Northern Africa</i>									
Algeria.....	1995	52	49	2.0	2.2	Direct support	Direct support	Direct support	Direct support
Egypt.....	2000	56	54	1.5	1.4	Direct support	Direct support	Direct support	Direct support
Libyan Arab Jamahiriya.....	1995	40	26			No support	No support	No support	No support
Morocco.....	1995	50	42	2.6	2.1	Direct support	Direct support	Direct support	Direct support
Sudan.....	1995	8	7			Direct support	Direct support	Direct support	Direct support
Tunisia.....	1995	60	51	1.7	1.8	Direct support	Direct support	Direct support	Direct support
<i>Southern Africa</i>									
Botswana.....	1988	33	32			Direct support	Direct support	Direct support	Direct support
Lesotho.....	1995	23	19			Direct support	Direct support	Direct support	Direct support
South Africa.....	2000	56	55	0.7	0.7	Direct support	Direct support	Direct support	Direct support
Swaziland.....	1988	20	17			Direct support	Direct support	Direct support	Direct support
<i>Western Africa</i>									
Cape Verde.....	2000	53	46			Direct support	Direct support	Direct support	Direct support
Ghana.....	2000	22	13	0.6	0.7	Direct support	Direct support	Direct support	Direct support
<i>Asia</i>									
<i>Eastern Asia</i>									
Mongolia.....	2000	60	46			Limits	Limits	Direct support	Direct support
<i>South-central Asia</i>									
Bangladesh.....	2000	54	43	1.8	1.6	Direct support	Direct support	Direct support	Direct support
India.....	2000	48	43	1.3	0.1	Direct support	Direct support	Direct support	Direct support
Iran (Islamic Republic of).....	2000	73	56	2.4	3.0	Direct support	Indirect support	Direct support	Direct support
Kyrgyzstan.....	2000	60	49			..	..	..	Direct support
Nepal.....	2000	29	26	1.2	0.9	Direct support	Direct support	Direct support	Direct support
Tajikistan.....						..	..	Direct support	Direct support
Turkmenistan.....	2000	62	53			..	..	No support	No support
Uzbekistan.....	2000	56	51			..	..	Direct support	Direct support
<i>South-eastern Asia</i>									

TABLE 11 (continued)

Country	Percentage of women using contraception			Trends (1990-2000) Annual increase in percentage using		Policy to provide access to contraceptive methods			
	Year	Any method	Modern methods	Any method	Modern methods	1976	1986	1996	2001
Brunei Darussalam .....						..	No support	No support	No support
Indonesia.....	2000	57	55	1.1	1.1	Direct support	Direct support	Direct support	Direct support
Malaysia.....	1995	55	30	1.0	-0.3	Direct support	Direct support	Direct support	Direct support
Myanmar.....	2000	33	28	3.2	3.0	No support	Indirect support	Direct support	Direct support
Philippines	2000	47	28	1.2	0.7	Direct support	Direct support	Direct support	Direct support
Viet Nam.....	2000	75	56	2.9	3.0	Direct support	Direct support	Direct support	Direct support
Western Asia									
Bahrain.....	1995	62	31	1.4	0.1	Indirect support	Direct support	Direct support	Direct support
Israel.....						Direct support	Direct support	Direct support	Indirect support
Jordan.....	2000	53	38	2.5	1.5	Direct support	Indirect support	Direct support	Direct support
Kuwait.....	2000	50	41	1.0	1.1	No support	No support	No support	Indirect support
Lebanon.....	2000	61	37			Indirect support	Indirect support	Indirect support	Indirect support
Qatar.....	2000	43	32	1.0	0.3	No support	No support	No support	Direct support
Syrian Arab Republic.....	1995	36	28			Direct support	Direct support	Direct support	Direct support
Turkey.....	2000	64	38	0.1	0.7	Direct support	Direct support	Direct support	Direct support
United Arab Emirates.....	1995	28	24			No support	No support	No support	No support
Europe									
Southern Europe									
Albania.....						Limits	Limits	Direct support	Direct support
Latin America and the Caribbean									
Caribbean									
Bahamas.....	1988	62	60			Indirect support	Indirect support	Indirect support	Direct support
Dominican Republic.....	2000	64	59	1.4	1.5	Direct support	Direct support	Direct support	Direct support
Haiti.....	2000	28	22	1.7	1.2	Direct support	Direct support	Direct support	Direct support
Jamaica.....	2000	66	63	1.2	1.3	Direct support	Direct support	Direct support	Direct support
Saint Lucia.....	1988	47	46			..	Direct support	Direct support	Direct support
Central America									
Belize.....	1995	47	42			..	No support	Indirect support	Indirect support
Costa Rica.....	1995	75	65	0.8	0.9	Direct support	Direct support	Direct support	Direct support
El Salvador.....	2000	60	54	1.3	1.1	Direct support	Direct support	Direct support	Direct support
Guatemala.....	2000	38	31	1.4	1.0	Direct support	Direct support	Direct support	Direct support

TABLE 11 (continued)

Country	Percentage of women using contraception			Trends (1990-2000) Annual increase in percentage using		Policy to provide access to contraceptive methods			
	Year	Any method	Modern methods	Any method	Modern methods	1976	1986	1996	2001
Honduras.....	2000	50	41	0.9	1.3	Direct support	Direct support	Direct support	Direct support
Mexico.....	1995	67	58	1.7	1.6	Direct support	Direct support	Direct support	Direct support
Nicaragua.....	2000	60	57	1.9	2.1	Direct support	Indirect support	Direct support	Direct support
Panama.....	1985	58	54			Direct support	Direct support	Direct support	Direct support
South America									
Argentina.....						Limits	No support	No support	Indirect support
Bolivia.....	2000	48	25	1.7	1.6	Direct support	Indirect support	Direct support	Direct support
Brazil.....	2000	77	70	1.1	1.4	Indirect support	Direct support	Direct support	Direct support
Chile.....						Direct support	Direct support	Direct support	Direct support
Colombia.....	2000	77	64	1.1	0.9	Direct support	Direct support	Indirect support	Direct support
Ecuador.....	2000	66	50	1.4	0.9	Direct support	Direct support	Direct support	Direct support
Guyana.....	1975	31	28			No support	Direct support	Direct support	Direct support
Paraguay.....	2000	57	48	1.8	1.7	Direct support	Indirect support	Direct support	Direct support
Peru.....	2000	64	41	1.5	2.0	Direct support	Direct support	Direct support	Direct support
Suriname.....						No support	Direct support	Direct support	Direct support
Uruguay.....						No support	Direct support	Direct support	Direct support
Venezuela.....	1977	49	38			Direct support	Direct support	Direct support	Direct support
Oceania									
Melanesia									
Fiji.....	1975	41	35			Direct support	Direct support	Direct support	Direct support
Papua New Guinea.....	2000	26	20			Direct support	Direct support	Direct support	Direct support
Vanuatu.....						..	Direct support	Direct support	Direct support
Polynesia									
Samoa.....						Direct support	Direct support	Direct support	Direct support

Source: The Population Policy Databank maintained by the Population Division of the United Nations Secretariat.

TABLE 12. FEMALE LABOUR FORCE PARTICIPATION
(Per cent)

Country	1980	1990	1995	2000
Africa.....	40	39.9	40.2	40.5
Eastern Africa.....	46	45.8	45.6	45.6
Kenya.....	46	45.9	46.1	46.1
Northern Africa.....	27.2	27.5	29	30.4
Algeria.....	21.4	21.1	24.4	27.6
Egypt.....	26.5	27	28.7	30.4
Libyan Arab Jamahiriya.....	18.6	18.3	20.7	23.1
Morocco.....	33.5	34.6	34.6	34.7
Sudan.....	26.9	27	28.4	29.6
Tunisia.....	28.9	29.1	30.5	31.8
Southern Africa.....	35.9	37.5	38.1	38.5
Botswana.....	50.1	46.8	46	45.4
Lesotho.....	37.9	36.5	36.8	37
South Africa.....	35.1	37.1	37.7	38.3
Swaziland.....	33.7	37.1	37.4	37.6
Western Africa.....	40.2	39.8	40.1	40.4
Cape Verde.....	34.4	39.3	39.5	39.5
Ghana.....	51	50.8	50.6	50.4
Asia.....	39.1	39.5	39.8	40.1
Eastern Asia.....	42.6	44.3	44.6	44.8
Mongolia.....	45.7	46.3	46.7	47
South-central Asia.....	34	32.1	32.9	33.6
Bangladesh.....	42.3	41.7	42.2	42.5
India.....	33.7	31.2	31.7	32.3
Iran (Islamic Republic of).....	20.4	21.3	24.3	27.1
Kazakhstan.....	47.6	46.3	46.3	47
Kyrgyzstan.....	47.6	46.2	46.6	47.3
Nepal.....	38.8	40.4	40.5	40.5
Tajikistan.....	46.9	42.2	43.5	44.9
Turkmenistan.....	47	44.7	45.3	45.9
Uzbekistan.....	48	45.6	46.2	46.9
South-eastern Asia.....	40.6	42.2	42.6	43
Brunei Darussalam.....	23.4	32.3	34.1	35.7
Indonesia.....	35.2	38.5	39.7	40.8
Malaysia.....	33.7	35.5	36.6	37.7
Myanmar.....	43.7	43.6	43.5	43.5
Philippines.....	35	36.6	37.1	37.8
Viet Nam.....	48.1	49.7	49.3	49
Western Asia.....	31.5	29.8	31	32.2
Bahrain.....	11	17	19	20.9
Israel.....	33.7	37.9	39.8	41.3
Jordan.....	14.6	17.4	21.0	24.4
Kuwait.....	13	22.7	31.2	31.3
Lebanon.....	22.6	26.6	28.2	29.5
Qatar.....	6.4	11.2	12.6	15.2
Syrian Arab Republic.....	23.5	24.4	25.7	27
Turkey.....	35.5	34.6	36.1	37.6
United Arab Emirates.....	5	11.6	13.1	14.8

TABLE 12 (continued)

<i>Country</i>	<i>1980</i>	<i>1990</i>	<i>1995</i>	<i>2000</i>
Europe	42.6	43.9	44.3	44.9
Southern Europe	33	37.5	38.4	39.3
Albania	38.7	40.2	40.8	41.3
Latin America and the Caribbean	27.9	32.6	33.8	34.8
Caribbean	34.9	36.7	37.9	38.9
Bahamas	43.4	46	46.6	47.1
Dominican Republic	24.7	27	29	30.8
Haiti	44.6	43.1	43	42.9
Jamaica	46.3	47	46.9	46.8
Saint Lucia				
Central America	26.4	29.5	31.3	33.1
Belize	21.1	21.4	22.6	23.9
Costa Rica	20.8	28.1	29.6	31.1
El Salvador	26.3	31.5	34.1	36.5
Guatemala	22.4	23.4	26.2	28.9
Honduras	25.2	27.7	29.8	31.8
Mexico	26.9	30	31.7	33.2
Nicaragua	27.5	31.9	34	36.1
Panama	29.9	32.4	33.9	35.3
South America	27.5	33.1	34.2	35
Argentina	27.6	28.5	30.9	33.2
Bolivia	33.3	36.9	37.3	37.8
Brazil	28.4	34.8	35.2	35.5
Chile	26.3	30	31.8	33.6
Colombia	26.2	36	37.6	38.9
Ecuador	20.1	24.7	26.4	28
Guyana	25.1	31.2	32.8	34
Paraguay	26.7	27.9	29	30
Peru	23.9	27.5	29.6	31.3
Suriname	27	29.7	31.9	33.7
Uruguay	30.8	39.2	40.7	42
Venezuela	26.7	31.3	33.1	34.8
Oceania	36.8	41.1	42.3	43.3
Fiji	17.2	23.4	27.2	30.6
Papua New Guinea	41.8	41.2	41.7	42.2
Vanuatu				
Samoa				

Source: International Labour Organization (ILO) 1997.

REFERENCES

- Henshaw, Stanley, Susheela Singh and Taylor Haas (1999). Recent trends in abortion rate worldwide. *International Family Planning Perspectives* (New York), vol. 25, No.1 (June).
- Hoodfar, Homa, and Samad Assadpour (2000). The Politics of Population Policy in the Islamic Republic of Iran. *Studies in Family Planning* (New York), fol. 31, No 1 (March).
- Larsen, Janet (2001). Iran's Birth Rate Plummeting at Record Pace: Success Provides a Model for Other Developing Countries. *Eco-Economy Successes and Setbacks*. Washington: Earth Policy Institute.
- McDonald, Mia (1999). *Meeting the Cairo Challenge: A Summary Report*. New York: Family Care International
- Singh, Rahul (1994). *Family Planning Success Stories*. New Delhi: UBS Publishers' Distributors Ltd.
- Singh, Susheela, and Deirdre Wulf (1994). Estimated Levels of Induced Abortion in Six Latin American Countries. *International Family Planning Perspectives* (New York), vol. 20, No.1.
- Singh, Susheela, and Josefina V. Cabigon, Alaf Hossain, Haidary Kamal and Aurora E. Perez (1997). Estimating the Level of abortion in the Philippines and Bangladesh. *International Family Planning Perspectives* (New York), vol. 23, No. 3 (September).
- United Nations (1995). *Report of the International Conference on Population and Development*, Cairo 5-13 September 1994. Sales No. E. 95.XIII.16.
- _____ (2000). *The World's Women 2000: Trends and Statistics* (United Nations publication, Sales No. E.00.XVII.14).
- _____ (1995). *The World's Women 1995: Trends and Statistics* (United Nations publication, Sales No. E.95.XVII.2).
- United Nations Children's Fund (1999). *State of the World's Children 1999*.
- UNESCO (2001). *Education for All: Initiatives, Issues and Strategies*. Paris.